MONTANA DIABETES PROJECT

QUALITY IMPROVEMENT REPORT

DQCMS Diabetes Quality Care Monitoring System

January— March 2012
Vol. V Issue 1

Report Highlights

The Million Hearts™ Campaign

The Million Hearts™ national initiative is focused on preventing one million heart attacks and strokes over five years.[1] As a healthcare professional, you play a key role in helping your patients with diabetes reduce their risk for heart disease and stroke and lead longer, healthier lives.

Quality Improvement Goals for the US and Montana

Million Hearts™ targets the ABCS (aspirin*, blood pressure, cholesterol and smoking). The national ABCS goals and objectives are to:

- Increase aspirin use among high risk persons.
- Increase hypertension control from 46% to 65% in the population and 70% in the clinical setting.
- Increase cholesterol control from 33% to 65% in the population and 70% in the clinical setting.
- Reduce smoking prevalence from 19% to 17%.

How do the Million Hearts™ objectives compare to the quality improvement (QI) goals in Montana? The Montana Diabetes Project set the following benchmarks for diabetes care in the clinical setting: increase hypertension control to 57% vs. the much higher national target of 70%; increase cholesterol control to 65% vs. the slightly higher national target of 70%; and reduce tobacco use prevalence to <13% vs. the national target of 17%. Trend graphs for these health indicators in diabetes care are provided on page 2.

Focus on the ABCS with Your Patients

Promote heart-healthy habits to your patients, such as regular physical activity and a diet rich in fresh fruits and vegetables. The Dietary Approaches to Stop Hypertension (DASH) diet is an excellent eating plan that includes consumption of more fruits and vegetables, low fat dairy, and less sodium and saturated fats.

Emphasize that blood pressure and cholesterol control reduces your patients' risk of heart attack and stroke. Prescribe appropriate aspirin therapy for high risk persons. Refer to www.cardiac.mt.gov for cardiovascular health resources.

Ask your patients about their smoking habits and provide smoking cessation counseling and tools to help current smokers quit. The Quit Line is a free service for all Montanans who want to quit using tobacco. The Quit Line is offering four free weeks of Nicotine Replacement Therapy (i.e., patches, gum or lozenges), three months of Chantix ($50 co-pay per month) or bupropion ($5 co-pay per month). Promote 1-800-QUITNOW (784-8669).

Ask your patients about what makes it hard for them to take their medications and help them find ways to make it easier. Reduce out-of-pocket costs for smoking cessation, blood pressure and cholesterol medications and services.

Use Health Information Technology and QI Tools

Use electronic medical or health records and/or the Diabetes Quality Care Monitoring System (DQCMS) along with QI interventions to track and improve ABCS performance. Contact the Montana Diabetes Project for assistance and support in developing and implementing QI projects for diabetes prevention and management. Combine your patient records with clinical decision support tools and patient registries.

Several existing investments in cardiovascular health and diabetes can be leveraged. For example, work to become a Patient Centered Medical Home, achieve meaningful use of electronic health records, or report on the ABCS-related measures in the CMS Physician Quality Reporting System (PQRS). More information on PQRS is available at www.cms.gov. As part of a statewide effort to prevent and improve the management of chronic disease, the Montana Department of Public Health & Human Services is developing a Chronic Disease Improvement Resource Guide to assist primary care practices in accessing resources and reporting PQRS measures. DQCMS assists providers in identifying patient populations and clinical outcomes related to PQRS measures.

Clinical prevention and care efforts align the ABCS across health systems, utilize health information technology, and incorporate other clinical innovations to promote the disease prevention and control goals of Million Hearts™. Visit millionhearts.hhs.gov to learn more.

*Note: When the ABCS are applied to heart disease and stroke, the "A" denotes aspirin; when applied to diabetes prevention and control, the "A" denotes A1C.

References
1. Frieden TR & Berwick DM. The "Million Hearts" initiative – preventing heart attacks and strokes. N Engl J Med 2011;365:e27.
2. Centers for Disease Control and Prevention. Million Hearts™ Partners Toolkit. Available online at: http://millionhearts.hhs.gov/resources/toolkits.html. Accessed 5/14/2012.

Diabetes Care Indicators
Montana Physician Offices and Diabetes Education Programs

Figure 1. Diabetes care indicators from primary care practices in Montana participating in the DQCMS project, 1st Quarter 2012 (N = 34 clinics; 11,655 patients)

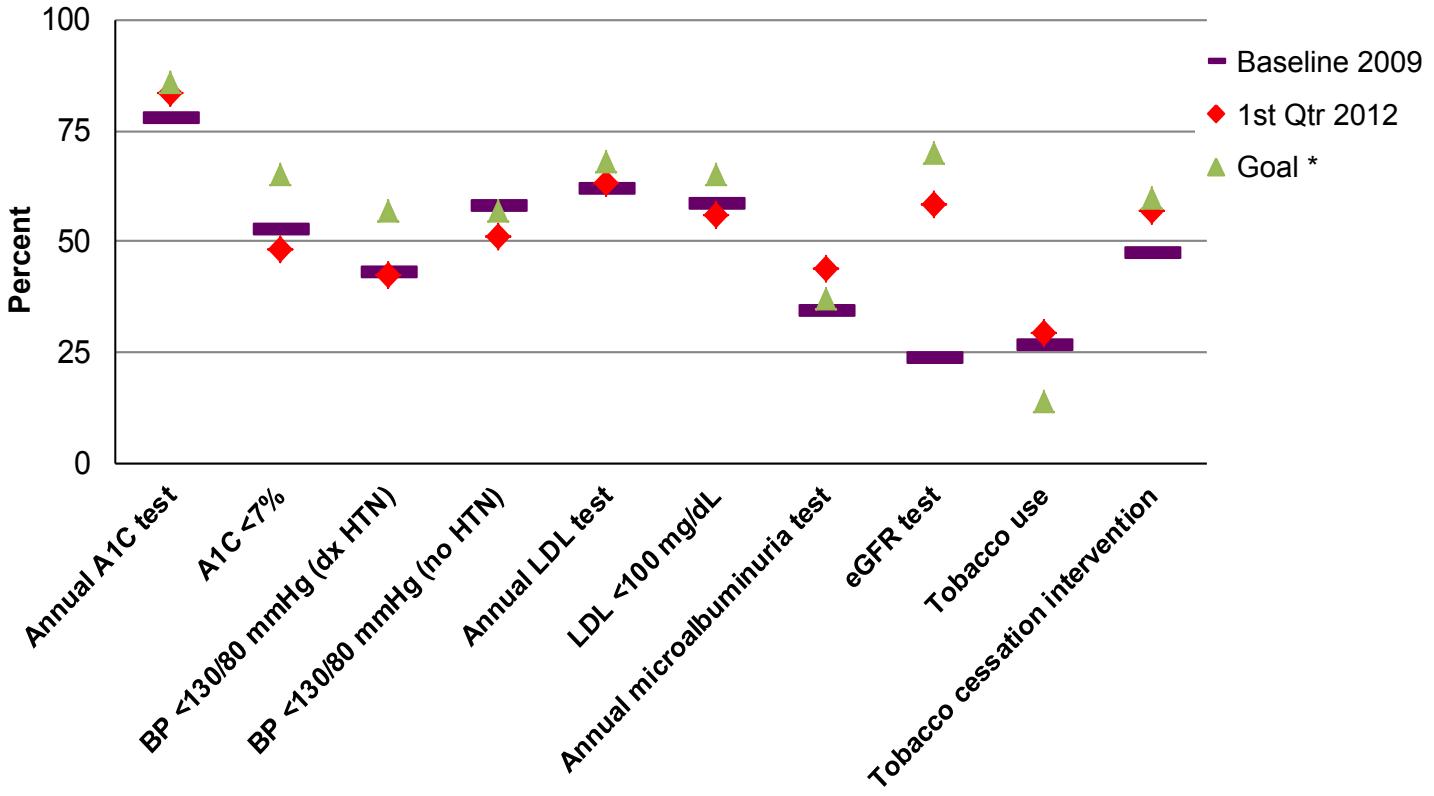
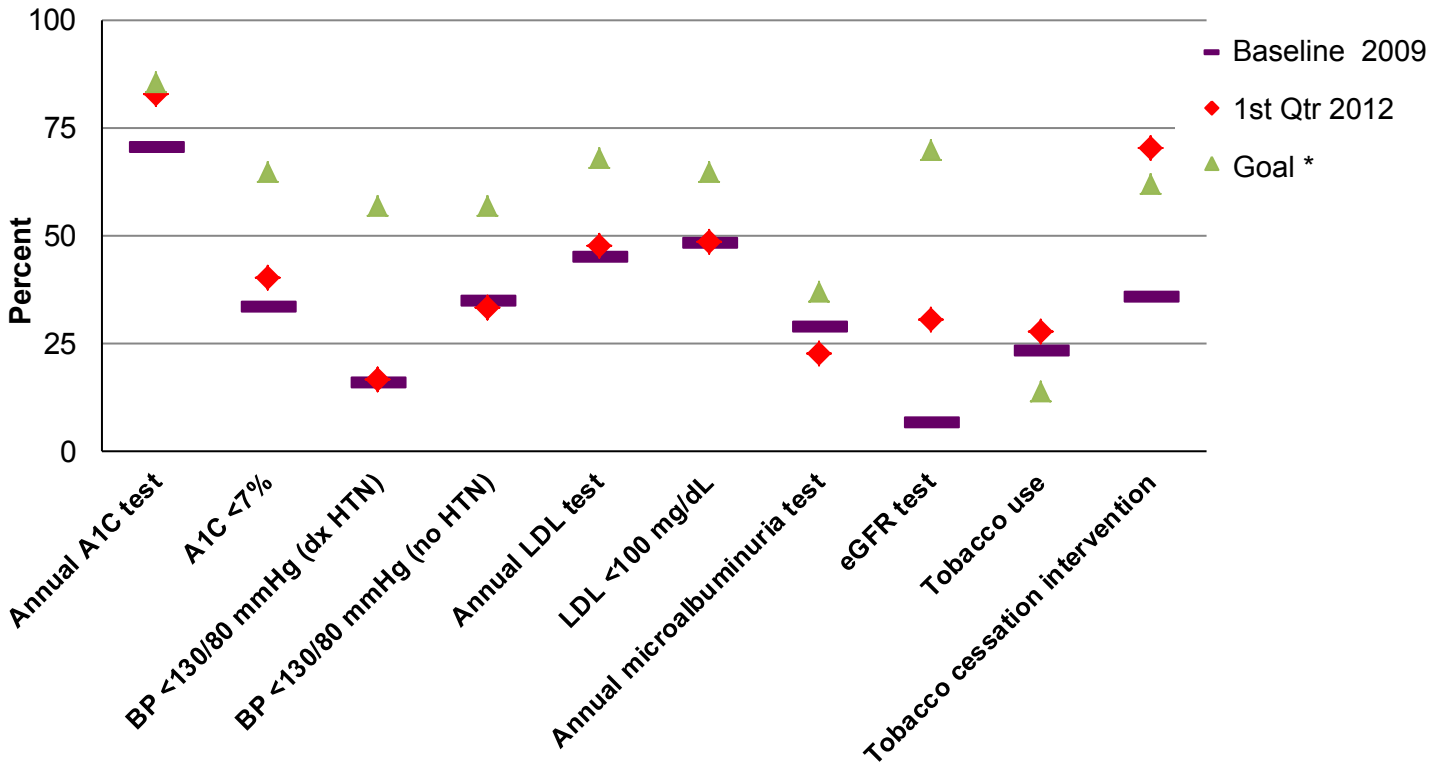


Figure 2. Diabetes care indicators from diabetes education programs in Montana participating in the DQCMS project, 1st Quarter 2012 (N = 5 sites; 1,314 patients)



Data presented are for adult diabetes patients seen within the last year.
**Montana clinical goals are defined in Vol. IV Issue 2 and based upon Healthy People 2020 or a 10% improvement from baseline.*

Success Story: Quality Improvement Project Outcomes in Vaccinations and Foot Exams

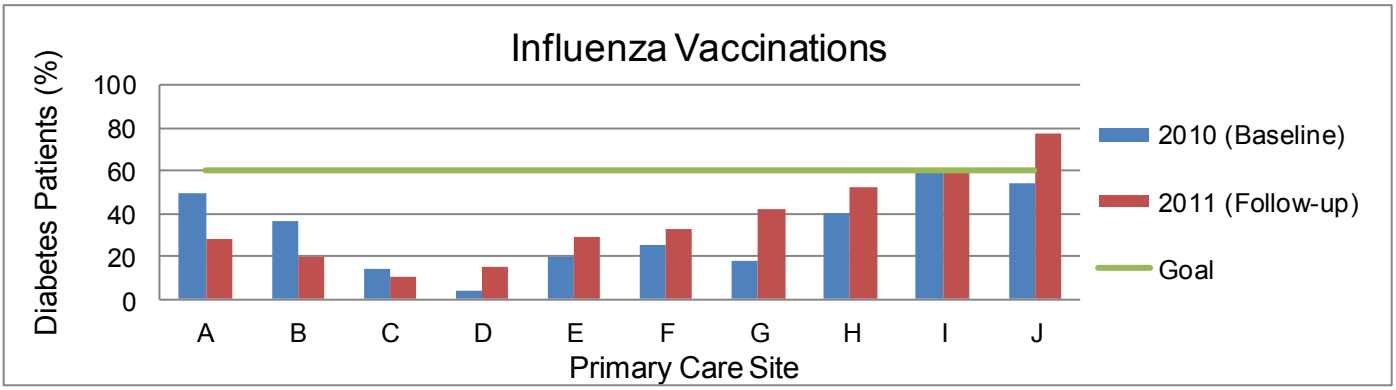
The Montana Diabetes Project (MDP) tracked the outcomes of several quality improvement (QI) interventions that primary care clinics and diabetes education programs implemented between 2007 and 2011. The QI projects involved a variety of diabetes care areas and assisted providers in achieving the standards of care set by the American Diabetes Association and national diabetes care objectives and interventions set by the Centers for Disease Control and Prevention Division of Diabetes Translation.[1,2] The overall QI goal is to reduce the burden of diabetes and its complications.

QI projects were developed for the following areas:

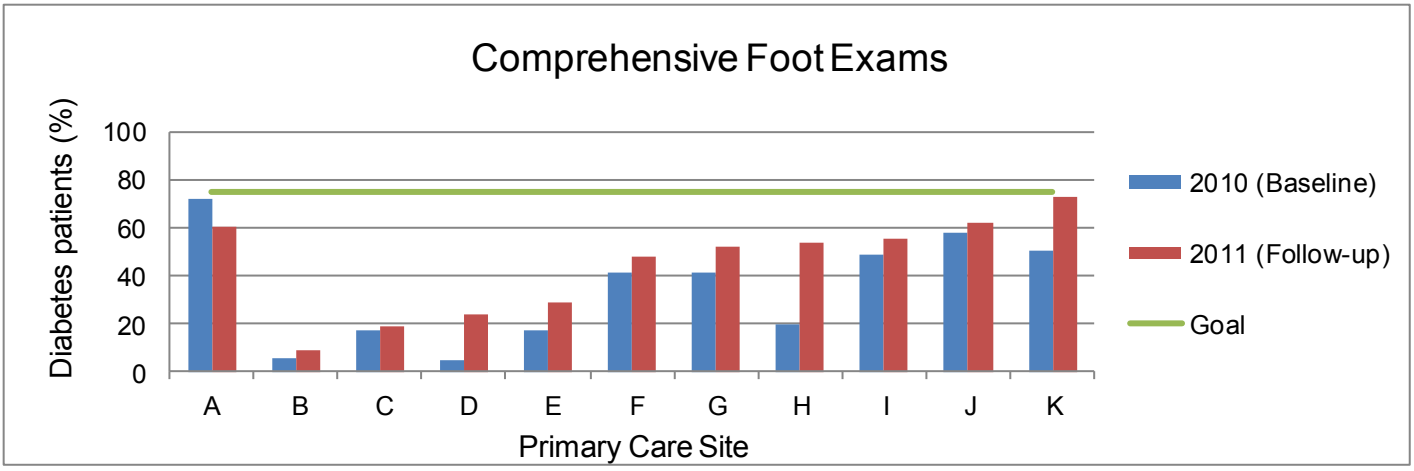
- ABCs of diabetes care, A – A1C < 7%; B – blood pressure < 130/80 mmHg; C – LDL cholesterol < 100 mg/dL
- Tobacco use cessation
- Chronic kidney disease (CKD) prevention and care, which includes microalbuminuria and eGFR tests
- Influenza and pneumococcal disease vaccinations
- Comprehensive foot exams

The results of two selected projects to improve care of diabetes patients are presented here: influenza vaccination and comprehensive foot exams. These interventions increased the percent of patients receiving influenza immunization or foot exams for 70% (n=7) and 90% (n=10) of sites that participated in the influenza vaccination and comprehensive foot exam QI projects, respectively.

Since 2007, 27 sites implemented an intervention to improve the percent of patients that received the seasonal influenza vaccination and document the immunization status in the patient record and diabetes registry. Results are shown for September 2010 through March 2011. Educating patients about the importance of being immunized for seasonal influenza each year and then asking and documenting if patients received a vaccine were the keys to improvement.



Through the foot exam QI project, clinic staff were instructed on how to conduct a comprehensive foot exam and document the results. The provider completed the foot exam follow-up. Adopting a team approach by involving clinic staff in conducting the comprehensive foot exams allowed the provider more time to address other issues.



The interventions are feasible; they can often be done with current staff and minimal time yet greatly impact patient health. To participate in these QI projects or develop one tailored to your needs, please contact your MDP QI Coordinator. Contact information is found on page 4.

References
1. American Diabetes Association. Clinical Practice Recommendations 2012. *Diabetes Care* 2012;35(Supplement 1).
2. Centers for Disease Control and Prevention. Diabetes Public Health Resource. Available online at: http://www.cdc.gov/diabetes/.

Resources

Welcome

The following healthcare facility joined the Montana Diabetes Project Quality Improvement Program:

- Roundup Memorial Healthcare, Roundup, MT

Congratulations

The following Community Health Centers received Patient Centered Medical Home Recognition:

- Glacier Community Health Center, Cut Bank, MT
  - Main site, PPC-PCMH, Level 3
- Community Health Partners, Livingston, MT
  - Main site, Bozeman, and Belgrade, PPC-PCMH, Level 3
  - West Yellowstone, PPC-PCMH, Level 1

Upcoming Events

Montana Diabetes Advisory Coalition Meeting
Helena, MT
July 20
* * *
Fall Diabetes Professional Conference
Bozeman, MT
October 18-19, 2012
For information call Susan Day at (406) 444-6677
* * *
Annual Montana Diabetes Educator Network Conference
Bozeman, MT
October 18, 2012
For information call Lisa Ranes at (406) 238-2205

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Montana Diabetes Project

www.diabetes.mt.gov

What's available on the new and improved website?

- Program goals and activities, State Plan for 2009-2014 and Burden of Diabetes in Montana Report
- Diabetes Quality Care Monitoring System Information
- Archived Diabetes Quality Improvement Reports
- Archived Clinical Communication & Surveillance Reports
- Resources for clinicians, educators, and schools